SHULMAN & ASSOCIATES
www.shulman-associates.com

660 Kenilworth Drive, Suite 102
Towson, Maryland 21204
410-296-9311 (FAX) 410-823-5225

CONFIDENTIAL PATIENT INFORMATION

PATIENT NAME LAST _____ FIRST _____ MIDDLE INITIAL _____

STREET _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____ WHOM MAY WE THANK FOR REFERRING YOU _____

DATE OF BIRTH _____ SEX _____ MARRIED/ SINGLE _____

EMERGENCY CONTACT _____ PHONE NUMBER _____

REFERRING PHYSICIAN _____ PHONE NUMBER _____

INJURY INFORMATION

IF AN INJURY: ☐ WORK ☐ AUTO DATE OF ACCIDENT_____

CLAIM #_____

ATTORNEY NAME _____ PHONE NUMBER _____

STREET _____ CITY _____ STATE _____ ZIP _____

PATIENT BENEFIT AND RECORD RELEASE

I AUTHORIZE SHULMAN & ASSOC. TO RELEASE MEDICAL INFORMATION AS IT IS NECESSARY TO BILL MY INSURANCE CARRIER. I AUTHORIZE MY INSURANCE CARRIER TO RELEASE PAYMENT OF INSURANCE BENEFITS TO DAVID H. SHULMAN RPT/ SHULMAN AND ASSOCIATES.

AUTHORIZED SIGNATURE _____ DATE _____

SHULMAN & ASSOCIATES
www.shulman-associates.com

660 Kenilworth Drive, Suite 102
Towson, Maryland 21204
410-296-9311 (FAX) 410-823-5225

CANCELLATION/MISSED APPOINTMENTS

1. IN OUR EFFORT TO SERVICE ALL OF OUR PATIENTS EFFECTIVELY WE REQUEST THAT YOU GIVE OUR OFFICE 24 HOURS NOTICE IN THE EVENT YOU NEED TO CANCEL YOUR SCHEDULED APPOINTMENT. PLEASE CALL 410-296-9311 TO CANCEL THE APPOINTMENT.

2. IF A PATIENT FAILS TO GIVE 24 HOUR PRIOR NOTICE OF THEIR INABILITY TO KEEP THEIR APPOINTMENT A FEE OF **$50.00** MAY BE ASSESSED. THIS FEE WILL NEED TO BE PAID PRIOR TO SCHEDULING YOUR NEXT APPOINTMENT.

3. IF YOU ARE OVER 20 MINUTES LATE FOR YOUR APPOINTMENT AND DID NOT CALL TO INFORM US OF YOUR LATENESS, YOUR APPOINTMENT MAY NEED TO BE RESCHEDULED.

4. IF YOU ARE OVER 20 MINUTES LATE FOR YOUR APPOINTMENT AND DID INFORM US OF YOUR LATENESS, WE WILL MAKE EVERY EFFORT TO SEE YOU THOUGH YOUR TREATMENT MAY NEED TO BE SHORTENED.

IF YOU HAVE ANY QUESTIONS REGARDING THIS POLICY PLEASE CONTACT VICKY OR MISSY AND THEY WILL CLARIFY ANY QUESTIONS YOU MAY HAVE.

I HAVE READ AND UNDERSTAND THE CANCELLATION/MISSED APPOINTMENTS POLICY AND AGREE TO BE BOUND BY ITS TERMS.

SIGNATURE _____

PRINTED NAME _____

DATE _____ **RELATIONSHIP TO PATIENT** _____

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

David H. Shulman, P.T.
Shulman & Associates
660 Kenilworth Drive, Suite 102
Towson, Maryland 21204

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below

Date:	Initials:	Reason:

Shulman & Associates
660 Kenilworth Drive, Suite 102
Towson, Maryland 21204
410-296-9311 (FAX) 410-823-5225

Patient Name: _____

Date: _____

Physical Therapy Patient Medical History

For what reason/diagnosis are your seeking physical therapy services?

_____

_____

Briefly describe your symptoms:

_____

_____

_____

Date symptoms began: _____

How did your symptoms start:

_____

_____

Which test(s) have you had regarding this problem? What was the result of the test?
(Check all that apply:)

☐ X-RAY Result: _____ ☐ CT SCAN Result: _____

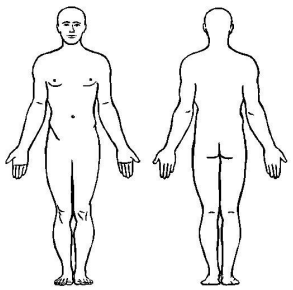
☐ MRI Result: _____ ☐ EMG Result: _____

☐ OTHER: _____

Choose a number from 0 to 10 that best describes your pain. 0 = no pain and 10 = unbearable pain:

Now: _____ At its lowest: _____ At its highest:_____

Please indicate on the figures where you have pain or other symptoms:



How much have your symptoms interfered with your usual daily activities?

☐ Not at all ☐ A little bit ☐ Moderately

☐ Quite a bit ☐ Extremely

What are some of your everyday activities that you cannot do or have difficulties with because of your current symptoms?

_____

_____

_____

_____

Patient Name: _____

Physical Therapy Patient Medical History (page 2)

Medical History: (Please check all that apply.)

☐ Cancer	☐ Congestive Heart Failure	☐ Angina	☐ Pacemaker
☐ Heart Disease	☐ High Blood Pressure	☐ Head Injury	☐ Stroke
☐ Epilepsy/Seizures	☐ Fainting/Dizziness	☐ Chronic Pain	☐ Joint Replacement
☐ Arthritis/Fibromyalgia	☐ Fractures/Broken Bones	☐ Osteoporosis	☐ Osteopenia
☐ Falls/Loss of balance	☐ Kidney Disease	☐ Vascular Disease	☐ Blood clot/DVT/PE
☐ Amputation	☐ Respiratory Disease	☐ Tuberculosis	☐ Swallowing Problems
☐ Liver Disease	☐ Depression/anxiety	☐ Bipolar disorder	☐ HIV/AIDS
☐ MRSA/Hepatitis	☐ Headaches	☐ OTHER: _____	

Surgeries: Please list & provide dates:

_____
_____
_____
_____
_____
_____

Medications: Please list below/provide a copy:

_____
_____
_____
_____
_____
_____

Patient Name: _____ **Date:** _____

Please continue on the back page!

Patient Name: _____

Physical Therapy Patient Medical History (page 3)

Do you have any allergies? ☐ YES ☐ NO If yes, please list below:

Allergy:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What doctors are you currently under the care of: (Please check all that apply & provide their name:)

☐ Orthopedic: _____ ☐ Neurologist: _____

☐ Dentist: _____ ☐ Neurosurgeon: _____

☐ Prim.Care Dr.: _____ ☐ OB/GYN: _____

☐ Cardiologist: _____ ☐ Rheumatologist: _____

☐ Psychiatrist: _____ ☐ Psychologist _____

☐ Other: _____

Have you been given any restrictions due to this or other conditions? ☐ YES ☐ NO
If yes, please explain.

_____

_____

What are your goals for physical therapy? (Check all that apply:)

☐ Decrease pain ☐ Return to Work ☐ Move with ease ☐ Improve balance/walking

☐ Improve function ☐ Other: _____

☐ Return to performing all pre-symptom activities such as:

_____

Further information I would like to share with the physical therapists is:

_____

_____

I, _____ agree that I have completed this form to the best of my ability and that any and all information is current and accurate.

Signature _____ Date _____

Patient Name: _____

BELOW INFORMATION TO BE COMPLETED BY PHYSICAL THERAPIST ONLY:

☐ PMH information was reviewed with the patient.

Additions/Updates to Medical history:

_____

_____

_____

_____

_____

_____ _____ _____

Therapist Signature/ Initials, Title **MD License #14829 #19017** **Date**

_____ _____ _____

Therapist Signature/ Initials, Title **MD License #14829 #19017** **Date**